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ABSTRACT

This work contains three papers presented at a conference held in 1976 for the purpose of examining, from a national perspective, the status of health and human services among Hispanic Americans. The first chapter, by A. Anthony Arce, concerns mental health policy in relation to the Hispanic American community. The author delineates some of the factors that account for the underutilization of mental health services by Hispanic Americans, including: an inadequate data base on this population, cultural heterogeneity, institutional policies and practices, manpower needs, inadequate research and evaluation, and insufficient community organization. The second chapter, by David Santisteban, approaches the problem of drug abuse among Hispanic Americans as a symptom of dysfunctional family structure, a problem created by pressures to adapt within the American social context. Recommendations are offered for drug abuse prevention, Hispanic American training, and an integrated strategy that includes legislation, research, training, and treatment. In the third chapter, author Fidelia A. Masi outlines the development of alcoholism treatment services in the work setting as a highly effective model of service delivery which, unfortunately, has rarely been applied to Hispanic Americans. The author recommends that occupational alcoholism programs be established for Hispanic Americans, and that Hispanic American counselors be trained to staff such programs. (Author/GC)

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Hispanic Mental Health, Drugs and Alcohol Policy Issues: Views from the Field

Jose Szapocznik, Ph.D.

Editor

Proceedings of the First National Conference on Health and Humar. Services

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Preface

There is a national trend toward greater emphasis in prevention and early intervention strategies in mental health, drugs and alcohol. The authors in this volume take a clear and firm stand in this direction. The emphasis is in reaching persons in their natural life contexts who are experiencing problems in living as a result of which mental illness, alcohol or drug abuse symptoms may become evident.

The old medical model of illness recognized the need for treatment only after the symptom had overshadowed the person. The emphasis was on the treatment of schizophrenics, criminals, heroin addicts and alcoholics. All of these having in common that the severity of their illness had achieved greater saliency that any other aspect of these persons' psychosocial gestalt.

Several decades of research and clinical experience have revealed that persons are overwhelmed by their mental, drug or alcohol related illnesses very late in a pathological developmental process. And, that once this stage has been reached, the likelihood of rehabilitation is slim, and the social and personal costs much too high to be acceptable.

Therefore, the clamour from the ranks of practitioners and researchers in the field is for developing the kinds of services that will prevent these problems or will arrest them at earlier stages of development. The trend is also toward a philosophy of service delivery that perceives the person in their human wholeness, including their environment. A holistic approach that is more consistent with Hispanic tradition.

This change is reflected in Richard Blum's[1] position paper prepared

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[1]Blum, R.H. Drug Abuse and Alcoholism: Issues and recommendations for the Democratic Party 1976. Journal of Drug Issues. 1976, 6 (4), pp 319-342.

for the Democratic Party in 1976. He noted that there has been "a pathology" oriented approach which uses the medical disease model. In contrast, he proposed that the object of treatment be the person.

In order to establish intervention strategies that place the person in the focal position, alternative models of service delivery must be developed. Models which reach out to the people in need; models which are geographically and psychologically accessible; models which take advantage of people's naturally occurring psychosocial support systems --people's strengths-- such as their families, ethnics communities, religious affiliations, and employment contexts; and, perhaps most important, intervention models that are in integrated harmony with the fabric of the consumer population, respecting their human dignity regardless of race, sex, ethnic background or belief system.

How this harmony between mental health, alcohol and drug abuse service delivery and the Hispanos can be achieved was the theme of this conference. The consensus was that our work begin with the development of appropriate governmental policy. Within the democratic process, minority groups such as the Hispanos can effect culturally sensitive legislation only if they are organized to achieve at least a modicum of political participation.

Involvement by Hispanos in the development of policy affecting the delivery of human services to our groups is the only way to insure that services will be in harmony with the fabric of our Hispano communities. The integration of consumer representatives into the policy making processes must occur at all levels - from local to Federal; from truly representative advisory and governing boards for service delivery agencies to appropriate

representation in Congress, Presidential Committees, and at all echelons of the Department of Health, Education and Welfare.

Conciousness of the need for political involvement arose from experience. As the authors in this volume document, Hispanos have underutilized mental health, drug, and alcohol treatment facilities around the country. When service delivery models were planned, established and conducted by non-Hispanos, the Hispanos tended not to accept these services, even when the need was great. Existing service programs have failed to assume an active responsibility in reaching Hispanos. Non-Hispanos providers have explained that Hispanos are not good candidates for psychotherapy. As the argument goes, however, providers argue that Hispano consumers will not accept their services and Hispano consumers argue that the providers are not offering the kinds of services that they will accept. As Dr. Arce points out in this volume, the institutional care systems in this country have been at odds with the cultural traditions of the Hispanic community.

The issue is very complex because in point of fact, very little is known about the kinds of service delivery models that are effective in attracting, maintaining in treatment and rehabilitating Hispano persons in need or at high risk for psychosocial dysfunctions.

The evidence is begining to indicate, however, that Hispanos can "intuitively" create culturally appropriate service delivery models for other Hispanos based on their clinical experience, their knowledge of the culture, and on the limited research findings available. For this reason, the authors in this volume argue in favor of placing Hispanos in positions to develop and establish services for their own people. A proposition

that at best would take years to implement since the number of well trained Hispano counsellors and administrators in the mental health, drug and alcohol abuse fields is very small compared to the size of the need .

In addition to involvement in the development of policy and in the conduct of services, and a service delivery philosophy of prevention and early intervention aimed at the whole person, there are other important themes that run through this volume. These include: (1) the inadequacy of reliable data bases from which to estimate the incidence and prevalence of psychosocial disorders affecting Hispanos; (2) the lack of sufficiently trained indigenous personnel to meet the human services delivery needs of our population; and (3) the dearth of research focused on Hispanos. The remediation of these problems emerge as clear recommendations from this volume.

This volume includes three chapters spanning three major categories of human service delivery areas: mental health, drugs, and alcohol. These chapters are based on presentations made by the authors during the First Hispanic National Conference on Health and Human Services, held in Los Angeles, California in September, 1976 and sponsored by COSSMHO - The National Coalition of Hispanic Mental Health and Human Services Organizations. The purpose of the conference was to examine, from a national perspective, the status of health and human services among Hispanos. Its goal was to strengthen and improve legislation, public policy, and professional practice in the fields of health and human services that impact on the Nation's diverse Hispanic population groups - Mexican- Americans, Puerto Ricans, Cubans, and other Latinos. This volume is limited to the proceedings covering the fields of mental health, drugs and alcohol.

The first chapter on "Mental health policy and the Hispanic community" is authored by A. Anthony Arce, M.D. He delineates some of the factors that account for the underutilization of mental health services by Hispanos, grouping them into six broad categories: inadequate data base, cultural heterogeneity, institutional policies and practices, manpower needs, inadequate research and evaluation, and insufficient community organization.

The second chapter, "Toward a conceptual model of drug use among Hispanos" is authored by David Santisteban. He, like Dr. Arce, also discusses the inadequacy of the available data sources in estimating the incidence and prevalence of drug abuse among Hispanos. Based on an early intervention model of service delivery, Santisteban proposes that drug abuse may be conceptualized as a symptom of dysfunctional family structures. From a psycho-cultural perspective, he suggests that adaptation to the American social context may cause special problems for Hispano families, and especially for those that are first or second generation immigrants such as the Cubans. He concludes by making vigorous recommendations for prevention, Hispano manpower-training, and an integrated Latino strategy for drug abuse that includes legislation, research, training, and treatment.

The third chapter, "Occupational alcoholism: An area for action for Hispanos" is authored by Fidelia A. Masi, D.S.W. She outlines the development of occupational alcoholism as a model of service delivery aimed at early intervention which is highly effective, but which, hitherto, is rarely if ever applied to Hispanos. While there is considerable popular support for the disease notion of alcoholism, and Dr. Masi endorses this notion, she also presents the mounting evidence favoring a broader definition of alcoholism's etiology and treatment.

There is a movement at the policy level to consider occupational programs for mental health and drugs based on the excellent track record of occupational alcoholism programs. Similarly, in industry there is a trend toward more broadly defined employee assistance programs which span the major categories of human services. Dr. Masi concludes with recommendations to expand our knowledge of alcoholism among Hispanos, to establish occupational alcoholism programs for Hispanos, and to encourage an affirmative action program to train Hispano counsellors in occupational alcoholism.

A set of recommendations based on the presentations of Drs. Arce and Masi, and Mr. Santisteban are found under "Final Comments" at the end of this volume.

Jose Szapocznik, Ph.D.
Editor

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Mental Health Policy
and the
Hispanic Community

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Historical Overview

Community mental health is a complex social movement with a long history. Its philosophical roots can be traced to the nineteenth century in the widely held belief that a harmonious relationship between man and his physical and social environment was essential to his well being and that such harmony depended on the existence of good social institutions. In terms of the mentally ill, this belief was translated into the concept of "moral treatment" which was characterized by sympathetic, understanding care and attempts to maintain the patient actively involved in life. However, while moral treatment was practiced in many institutions in Europe and America, the sense of social responsibility which characterizes the mental health movement today was not very strong. The care received by the mentally ill was not better than they had received previously.

In the first quarter of this century, Adolf Meyer's psychobiological formulations called attention to the complex interactions between the individual and his milieu as factors with significant, often inimical, impact on the individual's mental health. His ideas of work in "districts," similar to today's catchment areas, encompassed the role of the hospital and its staff in providing services outside of the confines of the hospital through dispensaries, home visiting, family planning, and collaboration with other agencies such as the schools and the police.

More recently, the contributions in the fields of social psychology and transcultural psychiatry have enriched our understanding of the relationships between socio-cultural conditions and mental illness. The emergence of sophisticated social science theory and methods has contributed to our understanding of the interaction between social and

cultural factors, and individual and group behaviors. Demographic and epidemiological studies have pointed out that symptoms of psychological distress are more prevalent among the lower social classes. Transcultural studies have shown that the stresses contributing to the development, onset and course of behavior disorders, the tolerance for social deviance and the methods of response to such deviance tend to be functions of socio-cultural factors such as family structure, economic system, political organization, and religious beliefs and practices.

These insights have forced a gradual conceptual shift in our orientation away from the traditional emphasis on intrapsychically determined psychopathology to a much broader perspective encompassing dynamic interactions between man and his society as major determinants in the emergence of mental disability. In the process, mental health has come to be viewed not simply as the absence of mental illness but as a state of "social well being", a concept reminiscent of the prevailing belief in the nineteenth century.

It is important, however, to emphasize that the concept of mental health has come to be used quite inclusively to cover a wide range of social problems. Many of these problems arise from the organization and patterning of our society and its institutions, as well as its prevailing value system. The brutal, dehumanizing conditions of life in urban slums, the persistent pervasiveness of racism and social discrimination, and the existence of inequities in the administration and delivery of justice, education and health care are but a few of the issues which have come to be viewed as falling within the domain of mental health.

In moving conceptually from the individual to the society at large, the mental health movement has decisively and irrevocably moved from the "health" field into the political arena. It is in the political sphere that public policy is formulated in the wake of compromises among competing self-interest groups, and frequently priorities set on the basis of political expediency, rather than on the basis of a rational assessment of societal needs. In politics, "the squeaky wheel gets the grease." Effectiveness in this arena, thus, depends on the development of a power base through community organization efforts. From the standpoint of community mental health, this requires that mental health workers assume a more active stance in effecting social change.

Conceptualization of Policy Issues

Prior to 1963, the formulation of mental health policy was essentially a governmental responsibility. Throughout the nation the prevailing philosophy was based on the medical model of mental illness. Under the auspices of the medical profession, the institutionalized mental health system created dual standards of care: high quality, individualized, psychoanalytically oriented psychotherapy for the affluent, and an almost complete lack of mental health care for the poor who were placed in custodially oriented state hospitals. The care of the most difficult psychotic patients was relegated to the least qualified personnel, while neurotics were assigned to psychiatrists and psychologists. The emphasis on adjustment to the prevailing values and culture of the majority became the goal of treatment, reinforcing the notion that minority groups were subordinate and inferior.

In 1963, President Kennedy became the first president ever to address the needs of the mentally ill on a national level. His call for a "bold new approach" in the care of the mentally disabled launched the community mental health movement on its present course. The resulting Community Mental Health Centers Act gave impetus to the coalescence of technical and scientific advances in disparate fields and legitimatized the community mental health movement.

Although community mental health is still an evolving concept, it can be differentiated from the medical model of mental illness by four characteristics. First, the target of community mental health is the entire population of a defined community and not simply those individuals who are labelled as mentally ill. Second, the objective is preventive in that is seeks to promote and maintain mental health rather than to treat mental illness exclusively. Third, community mental health seeks to involve the target population in the processes of development and implementation of relevant mental health services. Fourth, it seeks to promote, through research, a better understanding of the relationships between psychobiological factors and socio-cultural conditions as sources of stress that directly affect the mental health of individuals.

The aims of this national policy are implemented through the modification of traditional psychiatric hospitals, the development of community mental health centers, the integration of human service providers into relevant and responsive service delivery systems, and the support of research efforts and of manpower development. Today, the mental health system spends more money, employs more people, serves more clients and provides more services than ever before. There is, however, a gap between the philosophy of community mental health, and the present state of the art in community mental health. As Zwerling points out,

"the only significant change brought about ... has been a change in the location: the same patients as had been treated in traditional psychiatric programs are now being treated (in community mental health centers) by the same therapists trained to use the same approaches."

Community Mental Health for Hispanos

From the standpoint of the ethnic minorities, the challenge of community mental health remains essentially unmet. Demographic studies attest to the fact that ethnic minorities receive less mental health care than the general population. Further, among all ethnic minorities, the Hispanic probably receive the least amount of care as reflected by the degree of underrepresentation in consumer statistics in relation to their size.

While there are no adequate statistics as to the actual extent of the need for mental health services in the Hispanic community, numerous studies indicate that the need must be expectably great since it constitutes a high risk population. Investigators have pointed out that this population is subject to a number of "high stress indicators" which show significant correlations with mental illness and other self-destructive behaviors. These indicators include: (1) the cycle of deprivation and poverty (limited educational and occupational opportunities, substandard housing, depressed social status, and minimal political influence); (2) the stress of acculturation to a society which is prejudicial, hostile and rejecting; and, (3) poor communication skills in English.

On the other hand, studies on the utilization of available services have revealed that Hispanics are seriously underrepresented in

mental health service facilities and that their rate of drop-out after initial contact is extremely high. Among the factors cited as responsible for underutilization are (1) the exclutionary effect of middle class Anglo professional bias, (2) the reinforcement of stigmatization and alienation through the use of traditional methods and techniques of psychodynamic treatment, (3) the confusion and misunderstanding caused by language barriers and the psychocultural distance between patient and therapist, (4) the antitherapeutic intrusion of culturally determined stereotypes, (5) the discrepancy between the patient's expectations of the system and his actual experience within it, and (6) the inequality of services in the type and quality of diagnosis, treatment and care offered to this group in contrast to the type and quality of care offered to the Anglo middle and upper classes.

There seems to be general agreement that demographic statistics seriously underestimate the frequency and severity of mental health problems among Hispanics, that the care they receive tends to be of poorer quality, and that their underutilization of available services is greater than we know.

The factors that account for this critical situation are numerous and may vary among the various Hispanic groups and geographical regions. The major issues may be grouped into six broad categories: inadequate data base, cultural heterogeneity, institutional policies and practices, manpower needs, inadequate research and evaluation, and insufficient community organization.

Inadequate Data Base. The planning and delivery of mental health services depends on the existence of a reliable data base in order to develop accurate statistical information which identifies the demo-

graphic/social and economic characteristics of the population to be served and further refines these in terms of their health and mental health needs. In the case of the Hispanic community, its size is a highly debatable issue though it is generally agreed that it constitutes the second largest minority in the United States. The most recent estimates indicate that there are approximately 15 million Spanish speaking persons in the United States, making it the country with the fifth largest Spanish speaking population in the world. However, it has been argued that this information underrepresents the Cuban population by at least fifty percent, does not include Puerto Ricans living on the Island, and does not take into account an estimated six to twelve million Spanish speaking illegal aliens.

One of the major obstacles in data collection has been the lack of standard criteria for the identification of the Hispanic community at large and of its various subgroups. A common problem has been the confusing utilization of ethnic and racial concepts in ennumeration. Thus, in some agencies individuals are asked to identify themselves as White, Black, Puerto Rican, or other. More recently, the use of the "Spanish surname/Spanish speaking" designation has attempted to deal with this issue. This designation, however, does not take into account such factors as, for example, intermarriage and the ensuing acquisition of non-Spanish surnames. Finally, in their defensive struggle against racism and discrimination, members of the Hispanic community who may have achieved an upper socioeconomic status may elect not to identify themselves as members of their ethnic group and may prefer the use of racial designation.

The indadequacy of basic demographic data has probably resulted

in the loss, to the Hispanic community, of millions of dollars in Federal funds distributed on the basis of population counts and in the Hispanos being underrepresented in the process by which private and public agencies allocate resources to respond to unemployment, health, and other social and economic needs.

Another aspect of this issue refers to the accurate assessment of the need for mental health services. The incidence and prevalence of mental disability in the general population has not been determined reliably,much less among the minority groups. This is, of course, due in part to the lack of a well accepted definition as to what constitutes mental disability. Current estimates on the incidence and prevalence of mental disability among Hispanos are based on extrapolations from such studies as those done by Srole and associates in New York and Hollingshead and Redlich in New Haven. Such extrapolations fail to take into account the distinctive cultural values and unique familial and social structures which have a direct bearing on the individual's perception of his own state of mental health.

Cultural Heterogeneity. The Hispanic community in America is a culturally heterogeneous group composed essentially of three ethnic groups: Chicanos, Puerto Ricans and Cubans, in order of population. However, all other Central and South American countries are also represented in the Hispanic-American communities in varying but smaller numbers. It is a common practice to lump together all Spanish speaking groups as though they constituted one homogeneous mass, glossing over the multiple differences among and within Hispanic subgroups. While all share a common language and Spanish heritage, beyond these parameters the similarities diminish. Each group has incorporated the common

Spanish heritage within its own developing culture in degrees which are quantitatively and qualitatively different as a function of their specific social and geopolitical circumstances as well as accidents of history.

Each group has maintained its autonomy and is clearly distinguishable from the others. Each has its own life style, its own social context, its idiosyncratic patterns of feeling, thinking and behaving, its particular strength and weaknesses. While all groups face basically similar problems of adjustment to American society and have a limited number of alternative choices available, each arrives at different solutions. The tendency to generalize, to combine their problems and study them as a single phenomenon fails to acknowledge each group's uniqueness and individuality and may result in solutions inapplicable or inappropriate to each and to all.

The question of relevance of services is nowhere more critical than in this multicultural Hispanic context since diagnostic assessment tools and specific treatment interventions must take into account these significant cultural differences if they are to be accessible and effective.

Institutional Policies and Practices. In spite of the accumulated evidence supporting the critical interplay between the individual and the sociocultural system in the etiology of mental illness, the mental health system continues to be weighed down by the destructive forces of cultural stereotyping, institutionalized racism, professional elitism and irrelevant conceptualizations.

As Torrey points out, mental health services in the United States :

> are sharply bound by both class and cultural value...The vast

> majority of service, delivered by highly trained professionals stressing insight and autonomy, evolved to meet the needs of upper-class America... The resulting lack of class and cultural perspective produces services for minority groups that, when they exist at all, are both illogical and irrelevant....

Similarly, Fitzpatrick observes that,

> The system is largely irrelevant to the fundamental problems of the poor. It meets them in artificial circumstances (the clinic or the office), discusses their difficulties in a vocabulary and within a conceptual framework that has no relevance to their total world, and involves them in a treatment process which damages them by labelling them to themselves and to their communities. In seeking to treat the mental disorder in isolation from other problems, the system may hopelessly complicate the life of the poor person. Within this process from beginning (diagnosis) to end (treatment), the poor person comes off badly, is unable to protect himself, and sometimes ends up in a worse state than that in which he began.

The mental health establishment continues to be dominated by traditional intervention models based on the medical model. It relies heavily on psychoanalytic constructs which exclude considerations of the individual's current family functioning, community and cultural milieu as factors contributing to the emergence of mental illness. Further, such obsolete constructs fail to differentiate between culturally determined behavior which is adaptive or pathologic.

For the Hispanics, the outcome of such inappropriate practices, has been that the mental health system remains irrelevant to the way in which they define their needs for assistance. Their struggles with problems of self-esteem and with attempts to gain strength and

dignity are often labeled mental illness. Their reliance on culturally sanctioned religious beliefs and on patterns of family and social relationships for support is viewed as maladaptive and pathologic. In a world so beset with problems of sheer survival, participation in esoteric mental health services is relegated by the Hispano to the lowest priority and this is interpreted by mental health professionals as lack of motivation and commitment. In the presence of a staff that is often seen as judgmental, distant and uncaring, their attempts at seeking help result in the reinforcement of their sense of failure.

The major assumption by the mental health establishment have been that Western psychoanalytic constructs are universally applicable and that sociological assimilation of Hispanos holds the answers to their mental health problems. The stresses induced by pursuing the goal of assimilation into the melting pot result in an intensification of psychosocial and adjustment problems. Since the overwhelming majority of Hispanos live within socio-cultural "barrio" systems and within value systems that differ substantially from the Anglo value systems, it is in relation to the Hispanic system that the mental health system must be adapted and not the reverse.

In this context, adaptation means simply the process of modification so as to suit new conditions. The emphasis should be on the modification of traditional techniques as well as the development of new ones so that services provided to Hispanos become meaningful and relevant to their life experience.

There is a growing awareness that traditional modalities, even medical ones, may be effective in certain instances. For example, while it is essential to make a diagnosis of schizophrenia based on

knowledge of the Hispanic culture, there is no doubt that some of the traditional medical modalities, including chemotherapy, are effective in the treatment of this disease in the Spanish speaking. Studies have shown that Puerto Ricans who believe in "folk medicine" practices, also seek professional mental health services when they are relevant. Normand and his co-workers have demonstrated that brief group therapy is useful in helping patients with their presenting problems and preparing them to accept referral to longer treatment services. And Torrey has pointed out that whenever relevant services staffed by professionals become available to Chicanos, such services become the preferred mode of health care sought by this group.

Nevertheless, there is obviously a need to develop alternative techniques geared to the Spanish speaking based on a theoretical conceptualization and a set of therapeutic intervention methods that do not conflict with the traditions and values of the Hispanic community. Such values are based on mutual cooperation and not competion, on the strengths of the family and the network of social relationships, on the recognition of a person's dignity regardless of his station in life, on concepts of "personalismo", "respeto", "bondad", and other myriad subtleties reflected in the use of Hispanic terms which are foreign to Anglos.

Another recurring theme in this context is the juxta-position of the "traditional psychotherapeutic model" and the "human services model" which affect not only our Hispanic minorities, but all populations in need of human services. By human services is meant those occupations in which the interpersonal relationship between provider and recipient play a central role. The goals of human services involve changes in

the client's person or situation, aiming at better adaptive equilibrium or greater fulfillment of human potential. Human services encompass mental health, welfare, social services, some aspects of medical care, components of educational or rehabilitative assistance, public recreation, and services related to law enforcement, correction, probation and parole. Mental health, thus, is only one of the components of human services and not necessarily the pivotal one.

At the present time, these disparate services are provided by a multitude of public and private agencies, each with its own organizational structure, its own bureaucratic operational patterns, its own rules and regulations, and, most importantly, its own jealously guarded territorial jurisdiction and prerogatives. The task of integrating all of the above service providers into a relevant and responsive human services system staggers the imagination. Beginning efforts are underway, but much more needs to be done to break up monolithic organizational structures whose aim seems to be self-perpetuation.

Manpower Needs. One of the major problems assailing the mental health system in general is the lack of sufficient numbers of properly trained personnel to meet the staffing demands of the multitude of agencies engaged in service delivery. This problem is compounded by the highly competitive nature of recruitment and the disparities in salaries and benefits among agencies under public, voluntary and private auspices. Academic institutions and professional organizations, on the other hand, have not mounted truly systematic affirmative action efforts in recruiting Hispanos into training programs in order to develop a suitable professional cadre of bilingual, bicultural staff. Insufficient attention has been given to the need for financial support

in the form of incentive stipends and tuition scholarships to encourage Hispanos to achieve professional-educational goals. Furthermore, the curricula and training methods of existing programs continue to be tailored along traditional lines which emphasize credentialing and professional elitism.

Not only are Hispanos underrepresented among the consumers of mental health services, but also Hispanic professionals are significantly underrepresented among the personnel staffing mental health programs. Here again statistics are extremely inadequate, but reveal the same pattern of underrepresentation. As of May, 1975, of all employees in the Veterans Administration Hospital system, comprising 171 hospitals, the Hispanic population was represented in selected fields as follows: physicians, 5.0%; nurses, 1.6%; psychologists, 0.6%; social workers, 1.6%; activities therapists, 1.9%; and vocational rehabilitation specialists, 1.3%. This is in marked contrast to the estimated 8% Hispanic representation among the total population in the United States.

The 1973 Annual Report of the New York State Civil Service Commission discloses that it was with the Hispanic ethnic group that the greatest disparity existed between the proportion of New York State population which they comprised (8.0%) and the percentage of the surveyed work force which they comprised (2.5%). The Department of Mental Hygiene, the largest employer among all state agencies, had only 4% Hispanics among all of its employees. However, among the professionals and administrative personnel, Hispanics accounted for only 1.6%. The largest Hispanic representation of any New York state agency was found in the Drug Abuse Control Commission (7%) which is the seventh

largest agency. Significantly, in terms of the "human services" model, Hispanics were represented among other agencies to the following degrees: Labor, 2%; Correctional Services, 2%; Health, 2%; Education, 1%; and State Police, 0%.

The sensitization of Anglo professionals to the Hispanic culture as a means of enhancing the psychological accessibility of the services has been advocated by some but has received insufficient attention. Continuing education and in-service training programs have been designed to reinforce traditional professional roles rather than to develop professional community workers. Of course, whether "sensitized Anglos" can substitute for "indigenous professionals" is a highly debatable question, but as a stopgap measure the approach may have merit.

The most dramatic effect of the mental health manpower crunch has been the "community worker" explosion. It is generally believed that a "community worker" who is culturally congruent with his client may be a more effective helper than a community worker who is not culturally congruent. The former will know the client's language, be more sensitive to the client's problems, and will be better able to identify culturally appropriate solutions. The use of "community workers" is further reinforced by the politically liberal notion that it is desirable to make employment available to the ghetto dweller and compensate him for having been systematically disadvantaged, educationally and economically.

Community workers, however, have also been faced with the obstacles of racism and professional elitism. They are frequently categorized, not with regard to the professional function they perform, but rather by the racial and ethnic characteristics they have in common with their clients, such as "indigenous." Their roles have not been systematically

defined and their training in basic skills has been seriously neglected. In a field dominated by credentialism, they have little opportunity for advancement, are subject to exploitation and face an uncertain future. On the other hand, their effectiveness in a variety of functions and roles has not been rigorously examined with a view toward their more effective utilization.

Inadequate Research and Evaluation. Research, both basic and applied, is a field that is virtually unexplored territory in terms of the Hispanic community. Padilla and Aranda, for example, compiled a bibliography of all the literature which bears, directly or indirectly, upon the mental health of the Hispanic people. They searched all the issues of Psychological Abstracts through 1972 and the information files of the National Clearinghouse for Mental Health Information. This effort disclosed a total of only 497 references. Their conclusions constitute an indictment:

> There is a severe paucity of mental health research on the SSSS (Spanish speaking, Spanish surnamed). What little there is, unfortunately is of execrable quality. We have perused studies based on unwarranted assumptions; we have encountered the questionable use of statistical tests; we have complained of the absence of adequate controls or adequate matching of subjects or other indices of low quality research ..... (which) results in contradictory or incompatible findings.

There is a vast need for intensive and extensive investigation into the total Hispanic experience and its application to the delivery of mental health services. A cataloguing would include literally every phase of mental health, including normative behaviors, coping styles, ecological studies, improved methodologies, development of appropriate screening

and testing instruments, and so on. The implications of this very basic kind of knowledge for the development of alternative treatment techniques and the design and implementation of new programs are self-evident.

As to evaluation, with the increasing emphasis on quality of care, the entire field of evaluation is rapidly expanding into all areas of health care. Evaluating the effectiveness of mental health care, in general, is beset with numerous pitfalls given the state of our knowledge, the incredible intricacy of the problems, the difficulties in identifying goals and defining what we mean by "success" in terms of outcome and the need to control numerous variables in naturalistic settings. From the standpoint of the Hispanic population, these problems are compounded by the lack of basic knowledge on Hispanic mental health, alluded to above, and the cultural heterogeneity of the population. Padilla and Aranda, for example, point out that:

> Most of the research is on Mexican Americans, a little on Puerto Ricans, and <u>almost none</u> on any other SSSS group. Yet, as a few relevant studies have shown, one may not validly generalize from findings based on the Mexican Americans to the Puerto Ricans, nor viceversa. It thus goes without saying that one recommendation emerging from the project is for research with all SSSS groups, not just those convenient for researchers.

Community Organization. The advent of consumerism has profoundly affected the mental health system and such terms as community participation, community control and relevance have become part of the mental health vocabulary.

The objectives of community participation fall within two broad categories depending on the issues addressed: service and political.

From the standpoint of service, direct participation of service users, or their representatives, in the making of policy and the administrative management of mental health agencies is intended to maximize the provision of direct services by building trust and understanding between providers and consumers, as well as by identifying problems, issues and service goals. In addition, community participation serves a public relations function by informing clients who are either unaware of the services or are unwilling to seek them out. From the political standpoint, community participation addresses the issue of the realignment of power within the community in favor of those community interests which have been underrepresented in the past. The political context includes not only public politics but also the politics of social change.

The need for institutional change in mental health is gaining urgency with the rise of the ethnic group as a new sociopolitical form. This inevitably involves a redistribution of power. The nature of power is such that is is not readily transferred to those who lack it by the acquiescence of those who possess it. Its transfer entails a struggle, although not necessarily a violent, unprincipled one. There is, first, a philosophical struggle involved in the ascendancy of the notion that health care is a right and not a privilege. Secondly, there is the operational struggle as we define individual and collective roles in ensuring that this right is adhered to and served by public officials and private providers. What is at stake here is the gain of political leverage with which to reallocate resources to programs designed to address the specific concerns of the Hispanic minorities.

The climate is appropriate for undertaking this struggle. Governments are acknowledging that the fundamental responsibility for community mental health programs rests with the community,

operationalized through community advisory or governing boards. Moreover, the role of the public in the decision making process is being expanded. Federal, city and state governments are engaged in decentralization efforts to insure maximal citizen input and participation.

Furthermore, there are notable examples which demonstrate that community activism can produce significant changes in the institutionalized mental health system.

The Hispanic community represents an awesome presence in this country, at least in terms of size, if not yet in terms of its capacity to exert political influence. Its struggle for redress from generations of being subjected to racial and social discrimination has been thrust upon the national conscience, perhaps most dramatically through Cesar Chavez's unionization efforts on behalf of migrant workers. In scattered pockets, community organizational efforts are being undertaken and agencies addressing the needs of the Hispanos have been established. While the influence of the Hispanic community upon the social matrix of this country is perceptible, especially in metropolitan areas, the achievement of the goal pursued - to reach a position of preeminence in public policy and decision making - is still a long way off.

Power cannot be obtained and exercised through rhetoric alone. There is a great need to develop a national leadership among mental health workers and to sharpen our organizational skills to tap opportunities for input and to open up additional areas for participation. An organized leadership must then mobilize and utilize available manpower and community resources to develop a blueprint for action on a unified front. Mental health services can be one mean to accomplish the goals of community organization. The utilization of a variety of techniques to

promote self-awareness and enhance ethnic pride can lead to the identification of common sources of frustration and the redirecting of efforts in order to find solutions to these frustrations through the application of political pressure.

Comment. Clearly the above grouping of some of the salient policy issues of concern to the Hispanic community is for the sake of organization and clarity. They are not to be viewed as mutually independent variables but rather as part of a "gestalt." Effective community organization, for instance, through the exercise of political pressure has a decided impact on the slope of institutional policies concerning manpower, the design and implementation of relevant programs, and the stimulation of research and evaluation. On the other hand, a cadre of dedicated, sensitive, trained, bilingual/bicultural staff constitutes a more effective force in the process of community organization, in gathering accurate and relevant data, and in undertaking basic and applied research. However, the ultimate resolution of these issues rests on the joint efforts of government, institutions, service providers and the community at large.

Current Policies and Trends

It is obvious from the above discussion that the institutional mental health care systems in the United States have been at odds with the cultural traditions of the Hispanic community. Mental health agencies continue to dispense fragmented, irrelevant services tailored after the socio-cultural values of the majority. During the past four years, the Hispanic community has begun to articulate its needs in an increasingly coherent and consistent manner through regional meetings and participation in conferences of various professional groups. As one indication of their impact, the American Psychiatric Association has given recognition

to a Task Force on Mental Health of the Spanish speaking.

In areas where Hispanos constitute a substantial proportion of the population, institutions and agencies have begun to legitimize Hispanic concerns by supporting the organizational efforts of bilingual/bicultural staffs. At Hahnemann Medical College, for instance, the Department of Mental Health Services supports the activities of the Task Force on Puerto Rican Mental Health and the Puerto Rican Research Group. These two groups are composed of Puerto Rican professionals and interested Anglos who are engaged in making the community mental health centers programs more relevant to the needs of the large Puerto Rican community in Philadelphia, in developing transitional residential services specifically geared to Puerto Ricans who are being deinstitutionalized from the state facility, in establishing a training program for Puerto Rican community workers, and gathering relevant data on various aspects of Puerto Rican culture. In addition, the Department is one of five Departments of Psychiatry throughout the nation collaborating with the Hato Rey Psychiatric Institute of Puerto Rico in a world training program designed to sensitize Anglo professionals to Puerto Rican culture and to provide an opportunity for Puerto Rican psychiatrists in training to experience first hand the problems of Puerto Ricans in an alien society.

Certain changes are underway although they have not as yet become truly systematic and sustained. In 1970, after a series of confrontations between the Black Psychiatrists of America and officials of the National Institute of Mental Health, HEW Secretary Richardson announced the establishment of the Center for Minority Group Mental Health Programs. It officially came into being on July 1, 1972. It serves as the focal point for NIMH activities designed to improve the quality of life for

minority groups and to increase the number and competence of minority group members engaged in mental health research, training, and services. Its Minority Group Programs Section stimulates and supports (a) research designed to increase basic knowledge about minority group mental health, and (b) projects designed primarily for training minority group members for professional careers in mental health. In addition, it collaborates with other Institute programs and stimulates the dissemination of information. The Racism and Mental Health Programs Section addresses all aspects of research on institutional racism and its eradication.

Since 1972, the Center has awarded approximately 4 million dollars to 19 projects relating to Hispanic needs. The majority of these grants are managed by Hispanic professionals. The Center has Hispanic input at all levels, from support staff to professional staff.

During its initial year of operation, the Center had a budget of nearly 3 million dollars out of a total NIMH budget of approximately 600 million, or about 0.5%. This funding level, of course, could not begin to deal with all of the problems of the minorities. By 1975, the Center's budget had grown to 4.9 million dollars out of a total NIMH budget of 392 million, or 1.3%. The Center also serves an in-house advocacy function to encourage other NIMH dependencies to address the needs of minority groups.

The Center has provided "seed" funds for the development of five Research and Development Centers for minorities. Of these, one, the Spanish Speaking Mental Health Research Center at the University of California in Los Angeles, is for Spanish speaking.

In the field of training, the Center awards fellowships for the training of minority researchers to the American Psychological Association, the American Sociological Association, the American Nurses Association and the Council on Social Work Education. These organizations

will probably expand their programs to include the training of minority clinicians. The American Psychiatric Association currently has Center fellowship awards for the training of minority clinicians.

Finally, the Center also supports the organization sponsoring this conference - the National Coalition of Hispanic Mental Health and Human Services Organizations.

Another indication of change is the current Community Mental Health Centers Act (Public Law 94-63) enacted July 29, 1975. It provides that:

> In the case of a community mental center serving a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

There are obvious flaws with this bit of legislation, the most blatant of which is the provisions that a center serving a substantial population of non-English speaking clients whould be required to identify only one individual on the staff who will not only deal with this population directly but also serve as their ombudsman with all other staff.

Finally, President Ford has recently signed into law House Joint Resolution 92, which requires Federal agencies to expand and refine their methods for gathering, analyzing, and publishing accurate statis-

tics on Hispanos. This new law requires the Departments of Labor, Commerce, Agriculture, and Health Education and Welfare, as well as the Office of Management and Budget to improve, refine, and expand the collection of statistics on social, health and economic conditions for Hispanos. It also requires the Bureau of the Census to develop Spanish language questionnaires and implement an affirmative action program to employ Hispanic personnel. The significance of this law is that it aims at insuring that Hispanos will begin to receive an equitable share of Federal dollars and other resources in accord with their presence in the total population and in the light of their special and urgent needs.

How implementation of these two pieces of legislation is going to be monitored and by whom remains an issue of concern for the Hispanic community.

Conclusion

Throughout the discussion, I have delineated in very bold strokes the factors that I believe account for the underutilization of mental health services by a community that clearly can be anticipated to have great mental health needs. Specific recommendations for action will naturally emerge from a more detailed consideration of the parameters of each one of these factors during this and future conferences.

The main thesis of this presentation, however, has been that the basic issue confronting the Hispanic community in this nation is the gaining of political power to effect institutional change leading to the more equitable reallocation of resources and to the modification of current mental health delivery systems in consonance with the needs of Hispanos. Institutional change encompasses institutions within government as well as outside of government. The acquisition of political power requires the development of a cohesive community power base from which to operate in an effort to achieve proportional representation

in the policy formulation and decision making process.

While the Hispanic community must work together as a unit to achieve these generic goals, each subgroup must collect data and develop a body of knowledge based on their respective experiences in order to define accurately their needs and to provide culturally relevant services to each subgroup. Once these unique cultural definitions are achieved, our common language should enable us to coalesce into an effective force for social action.

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Discussion

Facilitator: Floyd Martinez, Ph.D.
Director
Mental Health Center of Boulder County
Boulder, Colorado

Resource Person: Abel Ossurio, Ph.D.
Deputy Regional Health Administrator
DHEW/PHS, Region VIII Office
Denver, Colorado

Dr. Arce mentioned that the mental health field is a social movement. It not only is a social movement, but it is also the by-product of other larger social movements. What are these larger social movements and how can they be utilized to facilitate change in the mental health field not only by the Hispanic minorities but perhaps by other minorities as well?

The Hispanic community is becoming a significant political force. The political arena is now and can be a very effective arena for the facilitation of change - something that has not been true at other times. I think that this possibility has to be exploited to its fullest -- not only at the national level but also at the state and local levels. A major focus in political action must be aimed at achieving some re-distribution of power with respect to decision making concerning re-

sources.

I think another major trend in this country is that there has been a change in the dynamic forces in the country in the direction of accepting the notion that we are a pluralistic society - that there are many different subcultures in this society, and that people have a right to be different without being penalized. While not all Americans agree with the philosophy of pluralism, there is sufficient support for this concept to achieve changes that perhaps were not possible before.

Another major trend is that mental health has moved very strongly into the political arena. I would submit that all of health has moved into the political arena in two major ways. One is the rise of consumerism with the challenge to the major service providing institutions of their absolute power to make decisions concerning how these services are going to be provided. Mental health participates in this kind of a challenge, as does all of health. The other is the notion that the major decisions that concern health should be made in the political arena with citizen participation rather than by the professionals; that like war, health is too important to be left to the health professionals. This may pose some possibilities as well as some hazards for those of us who would like to see a freer market place of decision-making at the same time that we have some concern with professional standards and quality of services. I think it is up to us as health professionals to meet this kind of dilemma head-on, and to maximize the possible usefulness that the introduction of political decision-making has made in the health field.

I think that in terms of financial expenditure there is a growing realization, particularly within the professional community, that increased investment in the capacity to provide care - whether this be mental health

or medical care - does not necessarily lead to proportional increments in the health status or social wellbeing of the population served. We have invested billions of dollars in increasing our capacity to provide tertiary care without materially affecting the health status of some populations. For this reason, the major policy change at the national level is now moving towards a prevention thrust that is directed to the diseases of adaptation, to the diseases that are associated with chronic stress, and at the same time those diseases or those detrimental health conditions that are associated with lifestyles. At this stage in the development of the health field, we are beginning to tackle in a preventive way the diseases that are associated with the way in which people adjust to their social, interpersonal and intrapersonal environments. At that point the distinction between mental health and health begins to disappear and I submit that this is a movement that potentially can provide a tremendous opportunity for the mental health field to develop knowledge applicable to preventive programs that will not be departmentalized into health and mental health but which will be designed to look at the person in his/her environment and to plan for the betterment of the total person. Yet, another major aspect to this preventive thrust is the notion that the individual has primary responsibility in the management of his/her own health, rather than what I would call a very inappropriate and sick dependence on the healer. In the past, this dependence has been manifested in an attitude that it is the healer's problem to cure the patient, as compared to an attitude that I have the capacity within myself to manage and to control what happens to me either physically or psychologically.

Resource Person: Grace Burriel, D.S.W
Director, Community Services,
La Frontera Clinic
Tucson, Arizona

I had several reactions to Dr. Arce's paper. My first reaction is to Dr. Arce's statement in relation to the underutilization of the mental health services by Hispanos: he failed to recognize that there are some mental health centers which are being utilized by Hispanos. I come from one of those centers and in that particular mental health center, Chicanos - Hispanos are over-represented. My second reaction is that in his discussion of the factors contributing to the underutilization of mental health services by Hispanos, Dr. Arce fails to cite a critical one, that is that many Hispanos continue to cherish the tradition of taking care of their problems,including mental health problems, within the family context. I found this to be the case in a recent research study that I conducted in Tucson, Arizona. I firmly believe that service providers underestimate the strength and resources of the Hispanic family in coping with their problems.

While I agree with Dr. Arce's statement that Hispanos are a high-risk population in relation to mental health needs, that is, exposed to the stresses which threaten mental health, such as poverty, unemployment, poor housing, low educational attainment, overcrowded conditions, and depressed social status, I feel that we have underestimated their coping mechanisms and strengths. <u>It could very well be that a contributing factor to underutilization may be that Hispanos are a strong and resilient people.</u> In my research, I have been interviewing Hispanos that are faced with multiple stress factors - and yet their ability to cope with their

stresses is incredible. I was amazed at their ability to cope with their life the way it is. I am finding a beautiful acceptance of life and of their situation in a very positive philosophical sense. To substantiate my findings, I administered the mental health status index and the well-being index, and found many Chicanos to be psychologically healthy, in spite of the conditions under which they live.

My last reaction addresses our general concern about the inability of mental health services to be responsive to the needs of Hispanos. I believe that mental health services can be made more responsive by: (1) having Hispanos on the boards of directors; (2) conducting extensive outreach and educational efforts; (3) having bicultural and bilingual staff both in direct services and in administrative positions; (4) locating the center in the Hispanic community; (5) addressing in treatment, the clients' presenting complaints, regardless of whether these are stated in terms of mental health problems, or more idiosyncratically; (6) using a family approach; (7) having an informal "ambience" in the center; (8) having limited red tape in obtaining services; and, (9) training the non-Hispano staff to the cultural aspects and needs of the Hispanic population.

In terms of policy formulation, it would be most helpful to develop a team of Hispanos to visit all of our communities and find out why mental health services are not reaching or being responsive to the needs of Hispanos. It would be fantastic if we could develop a group - an organization - a council - of Hispanos that would go throughout the country evaluating mental health services and helping the various service delivery systems to be more responsive to the needs in their Hispanic communities. To a small extent the Minority Center of NIMH in cooperation with the

NIMH regional offices is trying to provide technical assistance to mental health centers so that they can be more responsive to ethnic minorities. But the problem is that they tend to provide technical assitance to those centers which are requesting assistance and I think that those are the ones that perhaps need it the least. They are not providing technical assistance to those who have not requested their services and I feel those are the ones to which we need to address ourselves.

Resource Person: Marie McNabola, Ph.D.
Public Health Advisor on Social Planning
Division of Mental Health Services
National Institute of Mental Health
Rockville, Maryland

I would like to respond to the quote by Swerling, cited by Dr. Arce. He suggests that the only significant change brought about in treatment models - with the advent of Community Mental Health - has been the change in the location in which treatment is offered - from inpatient to outpatient. That is a simplistic statement because it fails to recognize the organizational and political differences in attempting to establish a different delivery system such as community mental health. In contrast to the old state hospital system, when community mental health centers accept federal money, they become subject to legislative mandates and federal regulations, having to establish exchange bases in order to obtain their resources which makes them more accessible to change. In order to correct some of the difficulties of the old state hospital system, the new act requires that the governing boards provide for citizen participation and representation. "Citizen participation" is a philosophical

notion. Unfortunately, there are very few communities that know how to reap maximum benefit from having a representative governing board. Participation in a governing board provides citizens with a real opportunity to have input into the kinds of services that are needed and to the kinds of populations that are not being served. It is also an opportunity for citizens to help providers learn how and in what way to benefit from the knowledge and strengths of community persons. Finally, I want to call your attention to minority women as a topic of special interest to all of us. All of us who belong to a minority or an ethnic group understand the pain of marginality. Women in minority group are marginal to a marginal group.

Resource Person: Albert Vasquez
Executive Director
Pilsen - Little Village Community Mental Health Center
Chicago, Illinois

The people and the Congress of this country do not support the kinds of prevention programs the Dr. Ossurio was advocating: preventive programs that will begin to deal with the kinds of problems that result in mental illness. In fact, most of our mental health centers are not mental health centers; they are mental illness centers because we are treating what has already become a problem. Within our own econo-communities, the supportive systems that promote the development or maintenance of mental health centers are not there. Many of our own people don't look at mental health centers as a resource. Why? Maybe it's because as Dr. Grace Burruel pointed out, we have a strong family system and supportive networks within the community.

That may be true in some cases, but in many cases it is not. Many families have serious adjustment problems and these are the families which, in general,don't have sufficient support systems.

Resource Person: Melba Chavez, D.S.W.
Director,La Frontera Clinic
Tucson, Arizona

A major issue of concern is underutilization of the mental health services by the Hispanos. This poses an epidemiological paradox: are we to assume that because Hispanos tend to underutilize mental health services, they suffer less than other groups from mental illness or mental disorders? Or is it that the Hispano family is more protective of its members with mental illness? Perhaps, underutilization really means that Hispanos consider the services provided as being totally irrelevant to their needs.

There has been a lot of speculation that Hispanos are not good candidates for psychotherapy because of their inability to verbalize, and to be introspective or gain insight? The question though is,how many of you Hispano psychotherapists have ever met a non-verbal Hispano? What is different, in terms of providing services for this population, are the cultural variables which have to be taken into account. We cannot isolate one variable such as language; rather, we must begin to look at the"ambiente," the context, in which the services are offered, the acceptability and the visibility - not only in relation to the location but also in relation to staffing patterns, and to develop an under - standing of the nuances and the syntax of the language. I take issue with the notion that Hispanos cannot utilize psychotherapy.I think that Hispanos

are excellent candidates for psychotherapy; the difference may be that it takes a little longer because so many Hispanos who are confronted with mental illness are also confronted with numerous situational stresses. Frequently, professionals fail to attend to these situational stresses under the pretext that they are "beyong their professionalism." If we expect Hispanos to utilize mental health services, it behooves the providers of these services to begin to examine what there is about their particular service delivery model that is irrelevant to this population.

Resource Person: Manuel Dominguez
Special Assistant to the Governor
Phoenix, Arizona

I think that in order to obtain the kinds of mental health programs that we need for Hispanos, we will need to become politically involved. And, in order to do this, we must develop the kind of community organization that can deliver votes.

Resource Person: Maria Romero
Technical Assistant Teen Coordinator,
Community Programs,
Bernalillo County Community Mental Health Center,
Alburquerque, New Mexico

I want to advocate in favor of comprehensive health care delivery centers which include mental health. The feeling among many Chicanos is that "if I go to a mental health center my neighbors will think that I am crazy." Therefore, I think that we can obviate the problems of under-

utilization by providing mental health services within the context of a comprehensive health care center.

I would also like to refer briefly to a problem that I have encountered with the present model of "indigenous paraprofessional" training. The present training tends to develop "junior psychiatrists" with the training procedure itself not being sensitive to the special needs and characteristics of the population. This model of training aims at changing Hispanos characteristics which are not necessarily pathologic, but rather cultural. And, why should we have to change the basic premises of our culture?

Toward a Conceptual Model of Drug Abuse Among Hispanos

David Santisteban

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Historical Overview

For many years, drug abuse was a low priority issue in the agenda of public opinion -- as long as drug use was confined to marginal and minority social groups. Recently, however, when drug use spread to all corners of the American social structure, when it hit the Senator's son or the Principal's nephew, a social crisis was created which called legislative attention to this issue.

Government response to drug abuse has changed drastically even in the last thirty years. First defined as a problem of crime, and later as one of social disorganization, it was not until 1972, with the enactment of the Drug Abuse Treatment Act, that primary emphasis was given to drug abuse as a health problem (Mushkin, 1975).

Susman (1975), for instance, reports that when heroin use in the big city slums became widespread following World War II, Congress enacted very punitive laws to deal with this new population of "social inferiors." The heroin users of the 1950's, however, were principally the poor slum-dwelling Blacks, Puerto Ricans, and Mexican-Americans. Not until the late 1960's, when the impact of the law began to be felt by white, middle class young people in suburban communities and on college campuses, did public opinion pressure to modify governmental policy about drug abuse. This reassessment has resulted in the development of new laws and practices designed to provide a maximum of flexibility in the handling of drug users by "encouraging" them to seek treatment.

The rapid shift in legislative emphasis toward drug abuse gave rise to a proliferation of treatment programs many of which were created in haste and frequently based on insufficient or unreliable assessments of

the existing needs. As noted by Bertram Brown (1975), Director of NIMH, foremost emphasis in the national drug abuse program to date has been on tertiary care, that is, treatment of addicted persons and drug abusers, with the goal of rehabilitating seriously impaired drug abusers and restore them to a level of psychological and social functioning. As Brown points out, however, the first priority in drug abuse programs should be to prevent, not to treat casualties after they occur. Yet, Legislative Alert News Service for July of 1976 reports that for Fiscal Year 77, NIDA's budget for community assistance will consist of about $3.5 million for prevention, a mere 2% of the total budget of $165 millions.

Drug Abuse Among Hispanos: Some Basic Issues

One of the problems with the concept of "drug abuse" is the lack of a well accepted definition, which tends to create confusion about the nature of drug abuse, its meaning and implications. Kupperstein (1975) for instance, notes that the general public believes that "street" drugs act according to entirely different principles than "medical" drugs. The result is that the risks of the former are exaggerated and the risks of the latter are overlooked.

Regardless of which formulation is used, however, reports on drug abuse have usually been limited to "nose-counts" of users. These statistics must be used carefully and with full recognition for their inherent limitations. Most prevalence statistics fail to address crucial policy questions about the meaning of drug abuse, the nature and dimension of such use, and the social problems posed by it. Nevertheless, as Kupperstein (1975) points out, much too frequently, statistics taken out of context are converted into policy decisions. Furthermore, survey data

may suffer from variability in definition of drug use/abuse and tend to disregard issues of reliability and validity. Finally, perhaps the most important drawback to the use of survey data derive from sampling problems such as representativeness of the sample and generalizability of the findings.

Most of the data reported on the prevalence of drug abuse among Hispanic populations have been obtained from admission rates to treatment programs. The Drug Abuse Reporting Program (DARP) offers one of the most complete sources of information currently available on demographic and background characteristics of contemporary drug users. Simpson, Curtis, and Butler (1975) looked at the variables of ethnicity, sex, and age among the 1971-1972 DARP population which consisted of 12,297 patients from 31 agencies throughout the United States, including one in Puerto Rico. About half(46%) of the patients were Black and about one-third (36%) were white. Puerto Ricans and Mexican-Americans represented 10% and 7% of the sample, respectively, while other ethnic classifications accounted for the remaining 1%. The age distributions within each of the ethnic groups were generally comparable, with the age range 21-25 predominant.

Reported drug use during the 2 months prior to treatment indicated that 66% of the sample used heroin daily, the use of other drugs was much less prevalent; marihuana was used by about 50% of the patients (12% daily), barbiturates and cocaine each about 30% (3-5% daily), and other opioids and drugs each by about 15% or less.

Within minority ethnic groups, prevalence rates associated with the drug use patterns were generally comparable between Blacks, Puerto Ricans, and Mexican-Americans. The only exception was an extremely low prevalence rate for the use of heroin and cocaine, in general, but a high rate for daily heroin use among Mexican-Americans. Among whites, the

use of nonopioids other than daily heroin was comparatively high. This same pattern was also prevalent among younger patients, and particularly among those under 18, with daily heroin patterns becoming more prevalent with increasing age. These trends were consistent within each ethnic group.

While the DARP data is based on large segments of patients who entered community-centered programs for drug abuse treatment, there are serious problems in attempting to use these data for epidemiological purposes. Simpson and Sells (1974), for instance, have pointed out that patient selection factors exist in these treatment programs. First of all, there is a factor of self-selection whereby patients have to agree to enter treatment for a drug problem in order to appear in the DARP statistics, the treatment agencies participating in the reporting program were oriented primarily toward admitting opiate addicts, and abusers of multiple drugs when opiates were among the drugs of abuse. This explains the prevalence of the opiate-related drug abuse patterns observed.

It is apparent that the self-selective factor of motivation on the part of individuals who enter treatment and the selective admission policies of the treatment agencies were both operative in determining the composition of the sample of patients included in the DARP study. The degree to which the DARP sample is representative of drug abusers and addicts in general is not specifically known and, hence, generalizations cannot easily be made regarding the prevalence and patterns of drug abuse in the larger population.

Ladner (1976) also argues that the observable rates are greatly affected not only by differences in the occurrence of the problem in the real population, but by external factors that contribute to a biased observation of these rates. In issues with a strong social disapproval

component (such as illicit drug abuse) or those whose observability is often partially a matter of social definition (as in the case of licit drug abuse and mental illness),incidence studies based on reported cases are often greately distorted by the process of reporting. Ladner, Page and Lee (1975) found that even voluntary admission treatment sites show ethnic and sex-related differences in utilization, independent of the ethnic and sex effects on the presenting complaint. The more limited in scope the treatment afforded by a given intake unit is, the more likely external biases will enter into the facility utilization rates (Ladner and Ladner, 1976). Finally, if entry into a treatment population for one problem is conditional on other characteristics of the patients that are only indirectly related to the incidence of the problem, the bias in these rates will be compounded and generalization made very difficult indeed. The prime example of such a confounded population is that of drug abusers in the Treatment Alternatives to Street Crime (TASC): the probability of a person entering that treatment population is dependend on the joint conditional probabilities associated with using illicit drugs, engaging in an illegal act, being arrested, having that arrest classified as a misdemeanor or third-degree felony and/or being a first arrest, and having a treatment slot available. Since patient background characteristics of age, sex and ethnicity all affect these probabilities, the determination of drug abuse rates from TASC statistics becomes very difficult indeed.

As Ladner and Ladner (1976) suggest, differences in service utilization rates for drug-related problems could be an outgrowth of a persistent bias toward a model of substance abuse treatment based on illicit drug abuse rather than the less visible but equally important dependence on licit substances.

The relationship between the use of a given drug and its salience as an observable drug problem thus seems to be a complex combination of the actual physical or psychological toxicity of the substance and the socio-cultural definitions of substance abuse as they affect both the recognition of a given activity as substance abuse and the choice of service sites for its treatment.

These are some of the methodological problems involved in the development of a working epidemiology of drug abuse on the basis of treatment data. An awareness of these methodological confoundings also have important implications for the development of intervention strategies if they are to be responsive to existing needs. Given treatment programs that are essentially responsive to criminal-justice definitions of drug abuse, it is hardly surprising that individuals with low narcotic abuse rates and those who are involved predominantly with licit substances would seek treatment outside the bounds of this illicit-susbstance-oriented treatment network. Therefore, these social and cultural factors affecting the perception of the drug problem and the willingness to enter treatment must be taken into consideration in developing treatment intervention strategies which are more culturally appropriate and ultimately more effective.

Drug Abuse Among Latinos: Towards a Conceptual Model

As indicated in our brief review of the literature, even the most complete studies that have attempted to the determine from treatment data the prevalence patterns of drug abuse among Hispanos, suffer from methodological flaws which limit the generalizability of the findings. Furthermore, the development of research and treatment methodologies appropriate to the Latinos has been seriously hampered by the absence of a comprehensive

conceptual model about drug abuse, its etiology and function for Latinos.

Although one must be careful with regards to generalizations about our different Hispanic groups in America given their cultural, linguistic, educational and adjustment peculiarities there are some basic tenets which seem common to our Hispanic experience and which can provide a basis for a conceptualization of our psychosocial problems. Perhaps, the most central issue and one which is shared by all Latinos (although admittedly to varying degrees) is the problem encountered in the process of cultural adaptation and the ensuing psychosocial stress.

For example, Ferracuti (1967) and Santos del Valle (1976) discuss the social changes that have taken place in Puerto Rico in recent years, pointing to the concomitant increase in drug addiction and other mental health related problems. Freudenberger (1975) also notes that when Puerto Ricans families migrate to the United States, families become disrupted. Their initial family structure becomes dysfunctional, often leading to intrafamily clashes between the first and second generation immigrants. The Puerto Rican family is often ill prepared to cope with the urban pressures of the large American metropolis. Intrafamily conflicts then are compounded by the many conflicts encountered when interacting with extrafamilial ecological systems, such as school, jobs, social agencies, etc. Similar problems have been identified with Mexican-Americans (Padilla & Ruiz, 1973) and Cubans (Santisteban, 1976; Scopetta, 1976).

As noted by Santisteban (1976), one of the most far-reaching effects of this process of cultural adaptation has been its impact on the family. Traditionally, the Latin family has been a source of support for its members. However, during the process of cultural adaptation it has become a source of intergenerational conflicts and interpersonal dysfunctions exacerbated by growing cultural differences between parents and

children.

This phenomenon of high levels of psychosocial dysfunction has been observed in the Cuban immigrants of Dade County. Many of whom are experiencing cultural shock and acculturation problems. Data from our research program at the Spanish Family Guidance Clinic have indicated that many of these Cubans seem to be handling the consequent anxiety and stress by resorting to drug abuse and misuse (Scopetta, King & Szapocznik, 1975).

The Symptom of Drug Abuse

Although drug abuse has been traditionally thought of as an illness, more recent developments in the field indicate the need to view this particular problem as a symptom of underlying psychosocial conflicts. With the advent of family theory and research, emphasis has been placed on the family as the most important unit of the social context in which this particular behavior can be conceptualized and treated.

Studies of the families of drug abusers have generally reported a high rate of family pathology, even including such symptomatic behavior as alcohol and/or drug abuse. Such results led some investigators (e.g., Rosenberg,1971) to conclude that "drug addiction is not only a manifestation of the individual's personality disturbance, but is symptomatic of a wider family problem." He suggests that the likelihood of drug abuse by a teenager or young adult depends on many factors within the extended family and in the ecological context of the family. Overt and covert conflicts in values within and between the nuclear and extended family may be a major source of tension, as well as value conflicts between the nuclear family on the one hand and the peer group, family occupational and school systems on the other.

Minuchin (1974) in his formulation of the theory of Structural Family Therapy, argues that the problems presented by the individual must be approached from a "social context" perspective. Thus in the family context, when one of the members is "having problems" or "being the problem," the identified patient's symptoms can be assumed to be a system-maintaining or a system-maintained device. In families with a drug abusing member, for instance, the structural family framework views drug abuse as a symptom. The symptom may be an expression of family dysfunction, or it may have arisen in the individual family member because of his particular life circumstances and then been supported by the family system. Minuchin argues that in either case, the family's consensus that one member is the problem indicates that, on some level, the symptom is being reinforced by the family system.

Implications for Clinical Intervention Strategies

An interesting phenomenon identified at the Spanish Family Guidance Clinic in Miami is that when Cuban families with drug-involved problems mobilize themselves for treatment of their psychosocial dysfunctions, they fail to identify drug abuse as their presenting problem (Scopetta, et.al., 1975) For example, the profile of presenting complaints showed that over 90% of the patients came to request help for more "traditional" mental health reasons such as family disruption, depression, psychotic and neurotic symptoms, acting out behavior, etc. Yet given a sufficiently long period of intake, drug-related problems were eventually uncovered in approximately 60% of these cases (Scopetta, et.al., 1975).

A study recently conducted at the Spanish Family Guidance Clinic (King, 1976) investigated the cultural considerations which might account for the particular choice of symptom that different Cuban families make (especially

drug versus non-drug use). Three groups of families were included: Drug Presenters (those families presenting drugs as a problem); Non Presenters with Drug Problems (those families which present other symptoms but which are later found to be abusing drugs); and Non Presenters with no Drug Problems.

To explore the relationship between acculturation and symptom-choice (drug versus non-drugs), an acculturation scale (Szapocznik, Scopetta, Kurtines & Aranalde, 1976) was developed and validated. It includes a self-reported Behavioral scale and a relational Value scale. King (1976) found that the degree of behavioral acculturation and the behavioral gap within the family were both significantly related to drug involvement. The Drug Presenter group showed higher levels of behavioral acculturation among the children and wider behavioral acculturation gaps between parents and children. For these families, there are acculturation conflicts both within the drug abusing individual and within the family system. This pattern was found strongly to be associated with illicit drug use as a symptom, especially among the adolescent members.

On the other hand, for the least acculturated group (Non presenters with Drug Problems) the abuse of licit drugs (mostly among the parents) seems to provide a means of coping with the acculturation process and its resultant stress.

These findings again support the notion that increased cultural adaptation conflicts are strongly associated with drug abuse. The specificity of the symptom (licit versus illicit drugs) however seems related to the individual's degree of acculturation.

A second issue studied (King, 1976), was the relationship between acculturation differences within the families and their ecological func-

tioning. To assess this relationship, scores obtained by family members on the Acculturation Scale were correlated with family ecological functioning scores as measured by an Eco-System Rating Schedule (King, 1976). The Eco-System Rating Schedule is an instrument designed by the staff of our program to measure the functioning of a family, viz. a viz. its various ecological systems (i.e., life-context). The ratings are grouped into eight areas of family ecological functioning: a) Educational; b) Occupational; c) Peer/Friendship; d) Legal/Criminal; e) Social Services; f) Recreational; g) Spiritual/Religious; and, h) Treatment Agency. Each item is evaluated separately by the therapist based on their observations of the family's behaviors on family members' self-reports, and on reports from representative of the various ecological systems. Within each system rating, several specific aspects (items) of functioning are identified.

The findings indicated an association between the general pattern of disruption in the families' ecological functioning and their relative degrees of acculturation. Of special interest here is the relationship between the family and the social services system. Results indicated that higher gaps in family values (low levels of acculturation among parents) are associated with lack of knowledge of available social services, lack of use of services, and conflictual relationships with service providers. This finding very definitely supports the contention that to effectively service the Hispanos, services must be provided in a manner sensitive to their values and expectations. Such values and expectations however, are seldom, if ever, recognized by the present service delivery system.

In looking at the relationship between drug-involvement and ecological family functioning, the analyses showed that for young persons there is a strong relationship between drug use and ecological disturbance in the

school and legal systems, with lowest levels of dysfunction in the non-drug group, next level in the non-presenters with drugs, and highest dysfunction in school and legal systems among the drug-presenters.

Neo-Structural Family Therapy was found to be equally as effective in the treatment and rehabilitation of drug as non-drug involved families. These findings suggest that when services are defined in terms of general psychosocial concepts and a holistic mental health approach, they are effective with Cuban families regardless of whether or not they are drug involved.

Neo-Structural Family Therapy seems to adapt very effectively to the expectations, values, traditions and behavior of our Hispano population which mobilizes for treatment usually in time of crisis, presenting concrete problems for which they want concrete and specific solutions. This mode of therapy is present-oriented and addresses itself immediately to the problems presented by the family. The therapist can intervene directly in the ecology of the patient, or work directly with the family, mobilizing members and teaching them alternative ways of transacting that are more effective in their new milieu. Such a model seems best suited to deal with the many problems of adaptation faced by our Hispanic community since it places the emphasis not on the nature of the pathology presented by the individual, but rather on his/her interaction with other systems in the ecology, and mainly on the family.

Some Basic Issues and Recommendations

Given the state of the art in the field of drug abuse among Hispanos, there are some very basic issues which must be immediately addressed in any systematic approach to this problem.

Hitherto, drug abuse treatment programs for the Spanish-speaking seem

to have been based largely on what policy makers "perceived" were the needs of the Latin population, frequently relying on Latin stereotypes and lacking an adequate data base upon which to make rational decisions. Therefore, the first step in planning should be the collection of a reliable data base which will provide policy makers with a more accurate picture of existing needs and one which can be used for more appropriate channelling of funds.

As Matlins (1975) points out, in addition to these fairly traditional purposes of data use, one other must be given its proper place: the purpose of politicking. Data can be used effectively to draw attention to the existence of the problem, and to mobilize the general public as well as policy makers in finding satisfactory solutions.

In the early 1960's when Great Britain's recurring balance of payments problem became a subject of almost constant attention in the daily newspapers, the prime minister was asked at a press conference why his country had not experienced similar problems during the 19th century. His answer was that many factors were different at the earlier time, the most important of them being "no statisticians."

The saliency of a major social problem is a function of the general public's ability to recognize it. Data can be used to point out a problem's existence as well as to suggest appropriate approaches to its solution. Objective assessment of needs on a continuing basis is therefore a task essential to the rational allocation of resources.

Focus on Multiple and Licit Drug Abuse

Another major issue in the drug abuse field, has been the failure to address the recent trend toward multiple drug use, as well as the abuse of licit drugs (Kupperstein, 1975).

The National Institute on Drug Abuse's, Drug Abuse Warning Network(DAWN) recently published a report indicating that Valium and other licit drugs used in connection with alcohol are the most abused drugs reported by persons seeking or admitted to care in the 2,300 emergency rooms, drug crisis centers, hospitals and other facilities monitored by the Federal reporting system. Many persons are abusing drugs other than heroin and are abusing different kinds of drugs concurrently. These findings are consistent with those reported by the Spanish Family Guidance Clinic revealing a high abuse rate of licit drugs by patients who do not present drug abuse as a problem at the time of admission. Therefore, more effective means of determining the incidence and prevalence of drug abuse as well as social, economic, and psychological concomitants are definetly needed so that funds can be more effectively allocated toward serving the broad drug abuse needs of the target Hispanic populations.

Intervention Strategies

The increasing awareness that drug abuse may be a coping behavior (rather than an indication of psychopathology per se on the part of the patient) and the growing evidence of a licit drug abuse problem especially among Latins brings us to formulate drug abuse services that are not remarkably different from a general community mental health systems model. This model has three primary implications for the delivery of drug related services:

1. The abuse or misuse of a given substance is not considered the pricipal distinguishing feature of the patient; rather, it is seen as a means of coping with a basic conflict in the individual or a reaction to system-induced stress;

2. Symptom reduction (in this case, abstinence) is less important to the individual's treatment success than the reduction of conflicts or

the development of alternative coping mechanisms for stress;

3. Prevention is the most valued solution to the problem of maladaptive substance abuse.

Brotman & Suffet (1975) point out three major approaches to prevention, including coercion or the threat of formal punitive sanctions; persuasion or education in the harmful consequences of drug use; and correction or the eradication of the presumed causes of drug use.

Throughout most of the twentieth century, the basic preventive strategy employed in America to reduce the use of illicit drugs has been the threat of punitive sanctions, as expressed through formal penalties codified in the law. The increasing rates of drug abuse in our population is an index of the ineffectiveness of this procedure.

There is however, a challenge to the development of an effective outreach, education and prevention program impacting on substance abuse as a coping activity, based on the notion that many potential abusers are reluctant to see this activity as a risk-producing situation. In the case of drug abuse, this reluctance is complicated by a very real concern for the consequences of admitting to an illegal activity. Even in the Latin culture, where illicit trafficking in tranquilizers involves little more than a trip to the corner"farmacia", there is a profound reluctance to admit nonmedical tranquilizer use to authorities or even service providers. Thus, once substance abuse is began to be used as a coping activity, the users become even less likely to seek assistance for their problems, now complicated with the substance abuse.

For these reasons, substance abuse outreach programs should be concerned with <u>education</u> as a prevention strategy.

At the same time, however, it is necessary to continue to develop

environmental intervention strategies which deal with the socio-cultural implication of drug use. The research studies conducted at the Spanish Family Guidance Clinic indicate the appropriateness of providing rehabilitative, treatment services to substance abusers in much the same family/ecological context as are effective in the treatment of other mental health problems identified by symptomatic behavior other than drug abuse. This conceptual model requires the study of family styles (interaction patterns, coping skills, etc.) within each of the different Latino groups, as well as study of the interactions between the families and their ecology (schools, jobs, etc.).

A strong component in any preventive or treatment oriented program for Latinos must also be concerned with community development particularly with respect to the reduction of stigma associated with seeking treatment, the identification of early symptoms of maladaptation and stress, and the fostering of a strong community awareness program.

Underutilization of Services

As noted above, there is a severe underutilization of services among Latino drug abusers as well as among potential consumers in other categories of mental health services. One possible explanation, however, is that available treatment is not attractive to those individuals potentially in need of help. It would therefore seem appropriate to study some of the variables which may be underlying this underutilization of services in our community. Potential deterents to entering treatment which might be evaluated include: inconvenient clinic hours or location; inappropriate clinic staffing patterns (i.e., not representative of the sex and ethnic composition of the area which it is supposed to serve); inappropriate treatment alternatives (i.e., treatment alternatives

which are not responsive to the existing needs or expectations of the community); and, excessive bureaucratic hurdles to admission. It is recognized that although there are certain formalities which must be maintained for the sake of administration and research, there is a need to keep the immediate needs of the clients as a foremost priority.

Manpower Training

A most important component of any effective intervention strategy is the availability of a program staff that is representative of the client population it is supposed to serve. Programs should therefore actively recruit professionals and paraprofessionals from the ranks of the target groups. Furthermore, "indigeneous professionals" need to be trained in special "culturally appropriate" intervention procedures.

Freudenberger (1975) in noting the need for role model figures who can act as a "bridge" between the client and the program argues that is is more difficult for a Latin youngster to identify with a successful Black or White role model than it is to identify with another Latino. Adame (1976) also notes the importance of each minority group having a sense of appropriate identification as a crucial variable for treatment success.

Congressman Edward R. Roybal (1976) points out that in Federally funded graduate training programs, minorities are greatly underrepresented according to an analysis of data from the National Academy of Sciences. Although minorities make up nearly 20% of the total population, they represent only 5% of graduate recipients, with Latinos comprising 0.8%. He also noted the need for Latino mental health professionals where Latinos represent only one-tenth of 1% of the psychologists and psychiatrist

in this country. Some of the specific recommendations in this area should therefore include: development of training curricula relevant to the Spanish speaking; recruitment of Spanish speaking faculty; and recruitment of Latino students into training programs.

A Plan for Action

In order to overcome this underrepresentation and ensure that the needs of our communities are reflected in Federal funding priorities we must develop a "Latino strategy" (Roybal, 1976). One that calls for an organized effort to influence and assess health program decisions at the national and local levels. This may include special attention to the Federal budget process, oversight of special health programs for minorities, a plan of action to coordinate the efforts of Latin groups to document needs and present them persuasively to legislators and officials, and the building of community coalitions that can take part in health planning and in the evaluation of service delivery. As noted by Santos del Valle (1976), the "reduction and prevention of drug and alcohol abuse require a comprehensive approach that integrates research, training, legislation, and treatment."

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Discussion

Facilitator: Ramon Adame
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Member, National Advisory Council on Drug Abuse Prevention
El Paso, Texas

I want to make two brief comments, in areas not covered by Santisteban's paper. The first is about biomedical solutions to the drug abuse problem. Back in the 40's we knew of about four or five drugs -heroin, marijuana, barbiturates, benzedrines and alcohol. Now thanks to the biomedical research profession and the legal drug manufacturers, we have numerous drugs to compound the drug abuse problem. This is precisely why I am so much against biomedical research. Heroin was invented to kill morphine; methadone was invented to cure heroin; now after methadone additional drugs are being developed to solve the drug addiction problems at the cost of millions and millions of dollars.

Biomedical research is extending the drug menu, and to me that is not the cure, that is not treatment. (There was an audience suggestion to recommend that Biomedical research money be diverted to other areas in drug abuse).

My second comment is that if we as Hispanos want to get the kinds of services that we need, we will need more representation in government and in government funding agencies.

Resource Person: Roberto Castro
Executive Director
El Projecto del Barrio
San Fernando, California

I have some concerns about the suggested emphasis on prevention. I believe in prevention, and I also believe that, at least with respect to the Chicano heroin addict, there are great needs for additional treatment funds, NOW. I also take issue with a conceptual model of drug abuse as resulting from the process of "cultural adaptation and the ensuing psychosocial stress." With respect to the treatment of heroin addicts, one must be very aware of the problems presented by the physical dependency, per se. And beyond that, of the psychological dependence on the drug which at times, far outweights the power of physical dependence.

With respect to effective treatment, I think that the key issue is to have counselors that are sensitive to the problems of the drug addicts. Certainly, there is a place for the professional in the treatment of drug addiction, but only if it can be integrated with knowledge from and sensitivity to "the streets."

Resource Person: Karin L. Thure, M.A.
Support System Supervisor
Pyramid Project
Walnut Creek, California

The research overview drew a very accurate picture of our current knowledge and the need for more accurate data on incidence and prevalence, so that public funds can be distributed to the groups with the greatest needs. And, clearly we don't have the information to determine where the needs are.

I'm happy to hear the emphasis on the abuse of legal as well as illegal substances. Here in California, the state is launching a media campaign on the abuse of prescription and over-the-counter drugs, as

well as on the mixing of alcohol with prescription drugs.

I couldn't agree more that the family is a major target for both prevention and treatment programs. We need to find more strategies to support families undergoing cultural stress before they develop to a crisis point, before they come into the clinic and say, "I've got a problem," and before the kid blows up in school bringing the community to bear on the family to get help. I think that we have to find ways of supporting the family, supporting kids in school, and reaching the youths before they get into trouble.

Through the Pyramid Project, which is a national technical assistance and information sharing primary prevention project, we have had an opportunity to hear from,and interact with Hispanic programs across the country. These programs seem to fall into three major categories. Some programs are directed at enhancing cultural pride, usually incorporating value clarification techniques to help people to recognize and accept their values differences from the major culture. Other programs are focusing on the development of the individual's interpersonal and academic skills. Yet other programs are "people helping people" kinds of projects engaging Chicanos and youths in service delivery.

In the field of prevention, there is a pervading feeling of success, which will continue to spread as programs get to share more of their experience with other programs.

Resource Person: Mario Romero

I hear so much talk about prevention, but in practice most so

called prevention programs are limited to drug education. Frequently these programs include scare tactics about what will happen "if you smoke a joint or take a fix."

If in fact drug abuse is a form of self-medication, and if a person living in a stressful environment is compelled to do something to feel better and, if it feels good to take the drugs, how can we tell our young drug abusers that it is bad to use drugs? They know that it doesn't feel good to be sober, to look at their environment and have to live with it on a day to day basis. It doesn't feel good to go to school and feel inadequate with ones peers, inadequate with ones own families, all over. And they conclude that it is better to stay drugged.

My point is that prevention efforts have to be aimed at changing the environment, at community development, and at increasing the power of community residents to make life better for themselves. We have to develop in people the feeling that they can bring about a better existence for themselves.

Another area for prevention to impact is on the general attitude of mental health professionals toward drug abuse. Can we educate our mental health professionals to see drug abuse in a non-judgmental way?

Jobs also need to be created as part of our effort in prevention. How can we convince someone that it is best to work, when they cannot find a job, and when"hustling"is an alternative to standing in an unemployment line?

OCCUPATIONAL ALCOHOLISM:
AN AREA OF ACTION FOR HISPANOS

by

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The Nature of the Problem of Alcoholism

The problem of alcoholism is widespread, reaching approximately nine million people in the United States with drinking problems. Half of all homicides and one-third of all suicides are alcohol-related. Alcohol is frequently involved in assaults and offenses against children. Roughly one-half of the five and one-half million arrests yearly are related to the misuse of alcohol. The cost to the taxpayer for the support of the criminal justice system for such alcohol related arrests, trials and incarcerations has been estimated at more than $100 million annually. Highway deaths related to alcohol total 30,000 annually exactly one-half the total number. The Department of Transportation has also found that one-half of all boating and private plane accidents are due to alcoholism. Perhaps, even more alarming are the 500,000 people injured annually in road accidents related to the use of alcohol. We cannot begin to estimate the personal loss due to family breakdown. Life expectancy is shortened by 10-12 years for alcoholics. Economic costs to the Nation are estimated at $15 billion per year. This includes $10 billion for loss of work time, as well as $5 billion for medical insurance , health and welfare services. Clearly, the social and economic costs of alcoholism are enormous.

The Disease Concept

As the recent publication "Facts About Alcohol and Alcoholism" published by the National Institute of Alcohol Abuse and Alcoholism states, "At present there is no definition of alcoholism that satisfies all." The following definition, however, is widely accepted (Facts, 1974):

> Alcoholism is a chronic disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or ordinary compliance with the social drinking customs of the community, and which interferes with the drinker's health, interpersonal relations, or economic functioning (Keller, 1958).

However, there is still discussion over whether or not alcoholism is an illness. The preponderance of evidence, seems to point in this direction. In fact, the American Medical Association and the World Health Organization have come to regard it as a specific disease entity. The American Medical Association in 1968 stated that "Alcoholism is regarded as a type of drug dependence of pathological extent and pattern, which ordinarily interferes with the patient's total health and his adaptation to this environment (Manual, 1968)".

Nevertheless, there is much interest today about the various psychological, physiological and sociological factors associated with alcoholism. Once drinking has been arrested the alcoholic is statistically as likely as not to have an underlying emotional illness as the non-alcoholic.

In the past all drinking problems were grouped together and assumed to be the same illness. It has been learned, however, that there are many kinds of drinking problems. It is noteworthy that epidemiologists have been able to identify stages of the disease, often referred to as the early, middle and late stages of alcoholism. The National Council of Alcoholism in its chart of "Alcohol Addiction and Recovery" list the following symptoms as characteristic of each stage:

Early	Surreptitious drinking
	Relief drinking
	Feelings of guilt
Middle	Promises and resolutions fail
	Efforts to control fail repeatedly
	Tries geographical escape
	Unreasonable resentments
	Family and friends avoided
	Physical deterioration

Late — Lengthy intoxication

Tremors and early morning sickness

Neglect of food

Physical deterioration

All abilities exhausted

Complete defeat admitted

Traditionally, over 90% of our treatment efforts have gone into 5% of the alcoholics already in the late phase, usually referred to as "skid-row" alcoholics. Recently, the interest has shifted, and efforts are being made to reach persons in the early and middle stages of alcoholism (70% of all alcoholics) while they are still living with their families, holding jobs and are accepted members of their communities. This change in emphasis is based on the assumption that rehabilitation is more likely when treatment is begun at an earlier stage on the road to alcoholism.

Treatment

At the theoretical level, a model for the treatment of alcoholism implies a concept of etiology, specific methods of intervention and a definition of expected outcomes and obtainable therapeutic goals. In practice, the relationship between etiology, treatment and outcome is not always clear, with this lack of clarity resulting from the proliferation of a great variety of different treatment modalities.

Typically, there are three general types of treatment settings, in-patient, intermediate and outpatient. In addition to the variety in settings, current approaches to the treatment of alcoholism encompass a broad range of therapeutic philophies and techniques, including: 1) psychotherapy and counselling derived from psychological models which view

alcoholism as symptomatic of underlying pathology; 2) drug treatments using pharmaceutic agents usually as an adjunct to other modalities; 3) behavior modification aimed at eliminating excessive alcohol consumption and establishing alternative modes of coping behaviors family therapy which treats the familial system and perceives alcoholism as a symptom of dysfunctional transactional patterns within the family; 5) AA emphasizing that alcoholism is a chronic incurable disease that can be managed only by lifetime abstinence.

Treatment approaches are as varied as the definitions of etiology of alcoholism, ranging from biological models of endocrine dysfunction, genetic characteristic and biochemical parameters, to the psychological model which include theories of personality traits, sociocultural background and environmental stress factors. Basic questions as to the nature and treatment of alcoholism, however, remain unanswered, bearing testimony to the lack of factual evidence and need for further research in the alcoholism field today.

National Policy and Legislation

Undoubtedly, the single most important event cristallizing the national concern over alcoholism and alcohol abuse was the passage of the Federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (The Hughes Act). Passed by the 91st. Congress on December 31, 1970, it established the National Institute of Alcohol Abuse and Alcoholism(NIAAA) as part of the National Institute of Mental Health. The Act authorized formula grants to be developed, a clearinghouse to be established for techniques in the field of alcohol abuse, and funding of innovative projects throughout the country demonstrating new strategies for combating alcoholism.

In 1973 this Institute was elevated in status to one of three making up ADAMHA along with the National Institute of Mental Health and the National Institute on Drug Abuse.

NIAAA's Director, Dr. Ernest Noble, administers four divisions in the Institute. The are:

1) Research, which has received the highest priority in the Institute;

2) Prevention, which includes community prevention as well as youth education;

3) Resource Development, which covers training, including the National Center for Alcohol Education, and four regional training centers; and

4) Division of Special Treatment Rehabilitation, which includes the special population branch with the following categories: Public Inebriate, Safe Driving, Black, Hispanos, Women, Aging, Youth, Rural and Occupational.

The Occupational category is the subject of major concern in this chapter. Section 201 of the original Federal legislation establishes that the Civil Service Commision is responsible "For developing, and maintaining, in cooperation with the Secretary and with other Federal agencies and departments appropriate prevention treatment and rehabilitation programs and services for alcohol abuse and alcoholism among civilian employees (Public Law 91-616, 1970, p.2)."

Federal Personnel Manual Letter 792-4 dated July 7, 1971 was also issued requiring other Federal agencies to establish employee alcoholism programs. The Department of Defense has included these programs as a line item in its budget. Following suit, other governmental agencies are now

developing programs in compliance with this Law. Action at the Federal level has given impetus to the states to legislate programs for their employees. Finally, county and municipal governments have begun to develop their own alcoholism programs.

Furthermore, Public Law 93-282 of May, 1974, established an Interagency Committee whose mandate is "to evaluate the adequacy and technical soundness of all Federal programs which relate to alcoholism and to seek to coordinate efforts undertaken by Federal Laws (Public Law 92-282, 1974, p.8)."

As a member of this committee I have been aware of the data collection from the various programs administered by many Federal agencies. Although the project is not yet completed, it is most revealing to see the extent of national involvement with all aspects of alcoholism by the Federal bureaucracy. For example, over 50% of the veterans in our VA hospitals suffer from alcoholism. The Department of Transportation has a vast safe driving campaign. The Department of the Interior is concerned with the problem of alcoholism among the American Indian population. Finally, the Federal government through recent legislation and with the support of Senators Hughes and Hathaway is giving high priority to occupational alcoholism programs even within its own bureaucracy.

Industrial Alcoholism

The Problem in Industry

Industrial alcoholism refers to the identification and provision of assistance to employees with a drinking problem within the work setting. Behind this concept lies an emerging field of practice which encompasses its own assumptions, treatment-modalities, referral mechanisms and manpower training procedures. Treatment in the work setting has the highest

success rates within the alcohol field, with rehabilitation statistics running well over 60%.

The obvious question to be raised at this point is "why the world of work?"

> Attention to the work world by alcoholism specialists has oftentimes been stimulated by the issue of costs, i.e. the notion that problem drinking by workers costs employers billions of dollars in terms of decreased productivity, lost time, accidents, etc. These costs are of three types: cost to employers, cost to problem drinkers and cost to society (Roman & Trice, 1976).

Since we know that a large proportion of chronic problem drinkers escape detection until they reach the final stages of the disease, it is safe to conclude that many of these undiscovered alcoholics work. Many studies have documented this fact. Trice (1962), for example, in his Society, culture and drinking patterns substantiates this notion. He concludes that 6-8% of the labor force has an alcohol problem. The National Council of Alcoholism, however, estimates a prevalency rate of about 5.3% of the labor force, or 4,500,000 employed alcoholics.

Many studies have shown that problem drinkers perform in a manner which can be very costly to the employer. Trice, Roman, Tichauer and Wolkenberg (19) report that problem drinkers:

1. Coming to work with a "hangover", show deteriorated manual dexterity and perception for as long as 18 hours.
2. Blue collar workers show increased scrap rate, clerical workers lower production and executives display less mental acuity and confused decision making.
3. Problem drinkers show a disproportionate number of whole day absences. This is especially difficult because it is unplanned.

Higher level employees will show partial absenteeism and come in late.

4) The behavior at work of problem drinkers affects the work of others and often results in morale problems.

5) High rate of off-the-job accidents result in high insurance costs to the company.

The National Council on Alcoholism estimates that the cost of alcoholism to industry considering only losses due to an estimated 25% average decrease in job performance, ranges from one to eight billion dollars annually (Sadler & Horst, 1972). The formula developed by the U.S. General Accounting Office is $3,000 annual cost impact per alcoholic employee. Dun & Bradstreet points out that after a three martini lunch, an executive with the power to negotiate and sign contracts could cost a company one million dollars in five minutes(Christopher, 1967). Alcoholism is industry's "billion dollar headache."

Since alcoholism is a progressive disease and often takes 10 to 15 years before it reaches the middle stages, the alcoholic employee is usually one who has been working for the company for a long period of time. He or she is a valued worker and more often than not occupies a position of responsibility either in supervisory, middle-management or top executive categories.

These facts reveal the high cost of alcoholism to society, the industrial world and the alcoholic employee. The identification and treatment of alcoholism in occupational settings can help reduce alcoholism-related losses to industry, but more important than the cost factor, is that the highest recovery rates for alcoholism are found in industry based alcohol treatment centers. The critical period in the development of the

illness is early in the alcoholic's life. During the early and middle stages, detection and care are most successful. This is the reason that to date the most successful programs in alcohol rehabilitation are found in industry. The importance of financial income and the status of holding a job seems to mean more to many alcoholics than we may have realized. According to the National Council of Alcoholism the average alcoholic will give up his family five years before he will lose his job.

In addition to the substantial importance of work to the early and middle stage problem drinker the following assumptions give credence to the emerging field of industrial or occupational alcoholism:

1. The primary mechanism in alcoholism is denial. The alcoholic will not seek help voluntarily and will continue to deny and "cover-up" his problem.He needs to be confronted. This precipitates a "crisis" which enhances the individual's motivation "to do" something about his drinking, thereby increasing his responsiveness to treatment efforts (Smart, 1974). Rather than having to "hit bottom" as AA states, job based alcohol programs can provide a chance for treatment before loss of job occurs.
2. The relationship between the employer and employee provides legitimate reason for intervention when the deteriorating job performance is documented. The employee is contracted to perform a specific job. If he is not performing up to his capacity then the employer has a legitimate opportunity to take action.
3. Steady employment often becomes the basis for denial of an alcohol problem. Supervisors and others in the work setting are in the important position of perceiving the problem and contributing to its solution. Families pressured by the stigma of alcoholism may be unable to deal with the problem The work place can, however, help

eradicate the stigma by insisting on help rather than waiting until dismissal is the only answer.

Developmental History of Occupational Alcoholism

Consolidated Edison and Kemper Insurance, Eastman Kodak and Dupont started some of the first industry based alcohol rehabilitation programs in the early 1940's. Prior to that time, when the problem became intolerable, alcoholism was handled by dismissal from the job. Roman and Trice (1976) indicate that the first alcohol programs in industry were originated in the medical departments of the large companies. Hayward, Schlenger and Hallan (1975) point out that despite the demonstrated effectiveness of such early programs, the growth of occupational alcoholism has been very slow. In 1959 there were only 50 such programs; by 1971, 300; and by 1973 this number doubled to approximately 600.

The National Council of Alcoholism (NCA) created an industrial unit in the 1960's. Under the direction of Ross Van Weigand, this Department has been stimulating interest in private companies to establish alcohol programs and providing consultation to industries upon request. NCA also publishes the Labor-Management Alcoholism Journal which is widely read in the occupational alcoholism field.

With the recent inception of the Occupational Branch of the National Institute on Alcohol Abuse and Alcoholism interest by private companies has been greatly supported. Today, for example, there are beginning programs for diverse employee groups such as airline pilots, policemen and university faculties.

The Occupational Programs Branch of NIAAA has as its special target group employed persons. The following are the major activities of the Branch:

1. Consultation services.

2. Establishment of occupational program consultants in each state.

3. Review of grant applications.

4. Support of demonstration projects.

5. Supervision of employee assistance program for Public Health Service.

The occupational program consultant in each state is the key individual promoting the development of local industrial programs. In 1972, each state received from the Branch a grant of $50,000 to fund two consultants for a three year period: One consultant was assigned to work with private industry and the other with state and municipal authorities. At the end of the first three year period, in the spring of 1975, some grants were expanded, others were terminated, and yet others were picked up entirely by the states. Most states continue to maintain one or two consultants while some states such as California, finance twenty-four.

The occupational program consultants have been found to be excellent resources for industrial programming. They are skilled in reaching out to new companies and providing them with information about alcoholism programs. They can also train supervisors and counsellors who are appointed by these companies.

As noted above, another important function of the Occupational Programs Branch is to fund demonstration grants. These grants provide a path for innovative methods to be developed, such as occupational alcoholism programs in small businesses as well as union based programs. This branch is also providing innovative leadership in the occupational field, funding evaluation programs and examining training questions and the manpower needs of the field.

The most recent organizational development in the field is the formation of the Association of Labor-Management Consultants on Alcoholism (ALMACA). It is a national organization based in Reston, Virginia, with over 600 members, including consultants and companies.

Ingredients of a Good Occupational Alcoholism Program

Occupational alcoholism programs aim at early detection of alcohol problems. Since denial is the basic defense of the alcoholic, the first step in the treatment of industrial alcoholism is to detect the problems, and to confront the employee with his or her problem.

"How is this done?" Hayward, Schlenget and Hallan (1975) suggest "constructive confrontation" as an answer:

> On the basis of documented deterioration of job performance, rather than demonstrated signs of alcohol abuse, the employee is confronted by his supervisor and referred to the company program. The employee is offered organizational support for his health problems and informed of the consequences (probation, suspension or dismissal) for failure to improve his level of performance (Hayward, et al. 1975, p. 5).

Clearly this philosophy introduces numerous provocative approaches that have applicability not only to alcoholism but to the entire mental health profession. The high rates of success in industry based on this technique, the highest in the field of alcoholism treatment, suggests that we may have uncovered a modality that may possess even broader application than alcoholism. One important aspect of why it works is that a job is usually very important to these working alcoholics, and when the job is made contingent on entering treatment, then the likelihood of early and effective treatment is enhanced.

How does a company organize such a program? The literature is fairly consistent in presenting specific steps which are considered necessary for establishing an effective occupational alcoholism program, among which, the most important are:

1. There must be a written company policy which describes the company's view of alcohol as a disease. Company policy clearly specifies the procedures for dealing with alcohol abuse in the work setting, including an outline of the basic philosophy for providing assistance, and for allowing time off for hospitalization as well as medical coverage [illegible] role and responsibility of the supervisor as the con-

tral referral source to the program is clearly delineated.

2. In unionized industries, both labor and management involvement is necessary in developing alcoholism policy as well as in supporting it. The union's role is defined along with the rights of the worker and presence of the union steward.
3. A company-wide program of education for employees is conducted in order to create awareness of the need and a broad source of support for such a program.
4. Training for supervisors must be furnished. Training should include an explanation of policy (or law as in the case of federal employees) and development of skills for confronting alcoholic workers. Role playing of the confrontation interview is common.
5. A diagnostic professional resource person, capable of interviewing troubled employees as well as diagnosing and appropriately referring them, is identified.
6. Treatment resources which will cooperatively work with the company's occupational alcoholism program are engaged as "treatment partners."
7. Follow through procedures including records, reviews and follow up must be developed.
8. A clear description of an enforceable confidentiality process is delineated.
9. A recent development in occupational alcoholism programs is to also include an evaluation component for the entire program.

A truly effective program must have all of these ingredientes. A written policy about alcoholism is not sufficient. A true commitment by a company to an industrial alcoholism program starts with planning the essentials outlined above.

There have been two general categories of work-based alcohol programs: industrial alcoholism and employee assistance. There has been much disagreement among the advocates of these approaches about the most appropriate method of service delivery. It is not the purpose of this paper to take sides with anyone of these approaches, but rather to discuss briefly these methods.

Original programs developed in the model of industrial alcoholism. They were usually administered by recovered alcoholics who themselves had found sobriety either through work based alcohol programs or other treatment sources. They would approach management and volunteer to provide assistance to other employees with alcohol problems. Usually, these individuals gave untiringly of their time and energy, and their effectiveness soon became apparent. Employers soon began to hire them as alcoholism counsellors. In many industries, these alcoholism counsellors were sent for further training to the Rutgers Summer School of Alcohol Studies. AA became their primary source of referral and alcohol was their main concern.

Employee assistance was a natural outgrowth of pure industrial alcoholism programs. Employee assistance began when alcoholism programs broadened their services to a host of problem areas with the hope of detecting alcoholics in their earliest stages. Since referrals to the company's employee assistance program was based on deteriorating job performance, workers suffering from a wide variety of emotional and social problems that affected their work output were referred for treatment.

There has been much controversy, in terms of policy and funding as well as from the ranks of labor, management, treatment staffs and consultants about the merits and drawbacks of each of the two models. There is strong sentiment that alcohol funds should not be used to support programs in the area of mental health and drug abuse.

This author concurs that to have true employee assistance there should

be funding from all three institutes in ADAMHA. However, it is obvious that the argument becomes arbitrary when it is left to company support. More programs are going the employee assistance direction and it appears that this will be the development of the future. In fact, more companies are including mental health and alcoholism in their insurance policies. This represents a major shift in the delivery of health care services, with tremendous implications for the entire mental health field.

Current Policy Trends

It would appear that there will be a shift in ADAMHA toward greater attention of work-based services. Already, NIAAA has been quite successful in developing occupational alcoholism programs:

> Occupational alcoholism programs are one of the most effective types of treatment programs because persons identified and treated in occupational programs are usually identified at an early stage of their illness. They seldom requiere detoxification or costly inpatient care. NIAAA treatment data shows that nearly 57% of those treated become abstinent within the first six months after intake. The confidentiality and success of these programs also encourages self referrals (Committee, 1976, p.11).

NIDA has already developed a small occupational component. The experience in many alcohol occupational programs, such as our own programs in Boston tells us that alcohol abusers are often drug or poly-drug users. Alcohol use is most frequently mixed with barbiturates and tranquilizers. Bourne (1974) advocating federal policy for polydrug abuse prevention states clearly that:

> there is a significant overlap between the people who encounter problems with these drugs and those who have difficulty with alcoholism.The overlap amounts to at least 30%. Programs to serve this population should seek to encourage programmatic linkages (Bourne, 1974, p. 253).

Although little is known about the number of drug abusers in the world of work, 222 of 536 companies in a 1971 nationwide survey by the National Industrial Conference Board were aware of some kind of drug problem among their employees (Clyne, 1975, p.3).

With the interest in the employee assistance concept, and the development of an occupational drug component at both NIDA and NIAAA, the author contends that it will be only a matter of time before NIMH also develops an occupational branch. NIMH has financed the Columbia University Industrial project summarized in the book Mental Health and the World of Work. It described the provision of mental health services to workers through a union contract.

The trend is clearly toward continued support from the government and the private sector for more industrial alcoholism and employee assistance programs. The delivery of alcoholism, mental health, and perhaps drug abuse services will soon be widespread throughout the work place or under work place auspices.

Alcoholism and the Hispanics

One of the newest areas for studies in alcoholism is the relationship between the cultural background of various ethnic groups and other drinking patterns. For example, the highest rates of alcoholism are found in the French, Irish American and Swedish. On the other hand, the lowest rates are found among the Jews, Greeks and Chinese.

Relatively little, however, is known about the drinking practices of the various Hispanic groups in the U.S. Two Latino Mental Health volumes published by NIMH (Padilla & Ruiz, 1973; Padilla & Aranda, 1974) refer only briefly to alcoholism. The authors found that most of the available literature was on Mexican-Americans, less on Puerto Ricans and almost nothing on other Hispanic-American groups such as the Cubans. These and other references, however, indicate consistent agreement in that there is a high incident rate of alcoholism among the Hispanics (Graves, 1967; Padilla & Ruiz, 1973). For example, the Los Angeles Medical Center reported that 52% of all Chicano deaths in 1970 were related to liver disease caused by alcoholism while only 24% of white and 22% of Black deaths were attributed to the same reason

(Nelson, 1973).

There are many questions with respect to the Hispanics' drinking patterns that need to be raised: Is alcoholism in Hispanics associated to acculturation and stress pressure, or to other causes? Since most Hispanics have low incomes, are alcoholism rates in these Hispanics related to low socio-economic conditions, or to other conditions prevalent among Hispanics? Only further research can answer these and many other similar questions.

Industrial Alcoholism and the Hispanics

In an attempt to obtain some references on industrial alcoholism programs for Hispanics, the author conducted several computarized literature searches. The computer data center at Boston College was used to search out the topics of industrial alcoholism and Hispanics. INFORM and Social Science Citation Index were used as data bases. INFORM contains approximately 10,000 documents produced by Abstracted Business Information, including 280 business and financial journals. The time period covered 1971 to date. Social Science Citation Index encompasses world wide journal coverage including over 300,000 records. Coverage was from 1972 to 1976. Not one single reference was provided by this search. Next, occupational alcoholism and Puerto Rican, Mexican-Americans and Spanish-Americans were cross indexed. Again, not one citation was found in all of the literature searched. Discussions were held with the Executive Director of the National Spanish Commission on Alcoholism as well as the Hispanic Office for Program Evaluation in Boston, who confirmed that there is no material on this subject.

We are, therefore, in an emerging field which has done virtually nothing for the Hispanic. Bearing this in mind, I recommend the following plan for action:

1. Mobilization for action should be at three levels, Federal, state, and industrial.

2. The first step for action must be to learn more about alcoholism and the Hispanic as well as the occupational field and the Hispanic. However, before we can effectively administer programs for the Hispanics in the work place we need to know more about alcoholism in Hispanics: its manifestations, incidence as well as cultural components. Special emphasis should be given to studying the drinking patterns of Hispanic women and Hispanic youths.
3. A special national effort should be made to request research funding from NIAAA in order to have Hispanos research some of the questions that we have raised, and to ascertain what studies are being funded by NIAAA around cultural aspects of drinking; around differences among Hispanic groups in the U.S.; and around Hispanic women and youth.
4. After these preliminary steps are taken, we will be ready to develop occupational alcoholism programs for Hispanos. The field is virtually non-existent. Yet, it may offer most hope for Hispanics with alcohol problems. If alcohol is found to be a major problem for the Hispanic, as the facts are beginning to indicate, then we need to insist that federal priorities give attention to the Hispanic in relation to alcoholism, and especially in the occupational context.
5. Several issues need close scrutiny in the industrial area: How is the Hispanic's alcohol problem affecting his/her work? Are Hispanics being served by employee assistance programs in proportion to their number in the work place? What are their special needs? Are there any Spanish speaking alcoholism counsellors in industry?
6. Encourage Federal grant applications for funding from the Occupational Branch of NIAAA? Technical assistance is available throughout the U.S. from this agency to help groups get started. Each state

has occupational program counsellors who are also available to help in the work area.

7. Affirmative Action programs in industrial alcoholism need to be developed. Hispanic counsellors should be recruited and trained.

There are many challenges for Hispanos that lie ahead in the field of alcoholism treatment rehabilitation. One of the most promising and exciting areas of work is occupational alcoholism: an area of action for Hispanos.

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Final Comments

The following recommendations for action emerge from this conference: In mental health, drugs and alcohol:

1. There must be more emphasis on prevention and early intervention programs of service delivery.
2. Hispanos must be involved in policy making that affect Hispanos in order to insure culturally sensitive legislation.
3. Hispanos must be involved in the governing and conduct of services to Hispano communities in order to insure culturally sensitive service delivery models.
4. A service philosophy that considers the whole person in their naturally occuring psychosocial context, and which takes advantage of environmental strengths such as family and employment (rather than focus on pathology) will be most effective with Hispanos. This holistic approach views the source of disability in the dynamic interaction between people and their psychosocial environments.
5. There must be increased emphasis on research aimed at: (a) establishing reliable and valid data bases from which to ascertain the incidence and prevalence of mental, drug and alcohol related disorders; (b) investigating the special service needs of Hispanos; (c) identifying features of service delivery models which are particularly effective with Hispanos; (d) evaluating the applicability of existing service delivery models to Hispano populations; and (e) developing innovative service delivery models which respect Hispano ethnic background, considers their socio-cultural realities, and are effective

in improving the quality of their lives.

6. Vigorous affirmative action program must be established to train Hispano professionals in the fields of mental health, drugs, and alcohol services. Specifically, training must be made available to these men and women which is culturally appropriate and sensitive to Hispano needs.
7. The integration of mental health, drugs, alcohol and other human services must be encouraged in order to present a coordinated prevention, early intervention and treatment strategy within the Hispano communities.
8. Additional support must be provided to special target groups such as women, children, youth, and the elderly.

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